Ark Valley Chiropractic

Chiropractic Registration and History

Patient Information

Date _____ SSN _____
Patient Name _____
Address _____
_____
City_____St_____Zip_____
E-Mail _____
Sex [ ] M [ ] F Age _____ Birthdate _____
[ ] Married [ ] Widowed [ ] Single [ ] Child
[ ] Separated [ ] Divorced [ ] Partnered for ___ years
Employer/School _____
Occupation _____
Employer Phone _____
Spouse's Name _____
Spouse's Birthdate _____
Spouse's Employer _____
Names and ages of Children _____
_____
_____
How did you hear about this office? _____

Phone Numbers

Cell # (___)_____ Home # (___)_____

In case of emergency, please contact
Name _____ Relationship _____
Cell # (___)_____ Home # (___)_____

Insurance Information

Who is responsible for this account? _____
Policy Holder's Birthdate _____
Insurance Company _____
ID Number _____
Group Number _____
Insurance Company Phone _____
Is patient covered by additional insurance? [ ] Y [ ] N
Insurance Company _____
ID Number _____
Group Number _____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Ark Valley Chiropractic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Ark Valley Chiropractic may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

I also agree to permit electronic communication, including but not limited to cellular devices and email, concerning any and all aspects of my account.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

Medicare Disclaimer

Medicare DOES cover Chiropractic manipulations, with the limitation of manipulations to the spine. Treatment must be determined to be medically necessary. **Medicare does not cover** therapies, supports, nutrition, examinations, x-rays, laboratory studies or maintenance therapy. **Medicare REQUIRES** that a treatment plan be **established and followed**, with the expected results of some functional improvement from sublaxations thus, re-establishing a degree of spinal health. **Medicare will not pay for anything, which it considers to be maintenance** therapy. By my signature I understand and accept this policy, also understanding that I am personally responsible for payment of any procedure, which Medicare determines not, payable under Medicare Part B, and I agree to pay promptly. I further understand that I am liable for my annual deductible and any changes, which are not paid by Medicare or my secondary insurance company.

I understand that it is required for me to have an examination to determine the subluxations, and I understand Medicare does NOT cover this exam and I am responsible to pay for the examination at the time of service.

_____ _____
Signature Date

Accident Information

Is your condition due to an accident? [ ] Yes [ ] No Date of Accident _____
Type of accident [ ] Automobile [ ] Work [ ] Home [ ] Other _____
To whom have you made a report of your accident? [ ] Auto Insurance [ ] Employer [ ] Worker Comp [ ] Other
Attorney name (if applicable) _____
Auto Insurance Company _____ Auto Claim Number _____